WageWorks®
www.wageworks.com

Health Reimbursement Account (HRA)
Pay Me Back Claim Form

TOLL-FREE FAX: (855) 291-0625
Or, mail to: Claims Administrator-FBWW, PO Box 14326, Lexington, KY 40512

DO NOT USE A FAX COVER SHEET
to ensure speedy processing.

ACCOUNT HOLDER INFORMATION

Last Name

First Name

Participant SSN* (last 4 digits)

Employer Name: MINNEAPOLIS

Spouse/Survivor SSN* (last 4 digits) (if applicable)

CERTIFICATION AND AUTHORIZATION

Signature of Account Holder X_____ **Date**_____

I certify that the information on this form is accurate and complete. **I am requesting reimbursement for eligible expenses incurred by myself or an eligible dependent while I was a participant in the plan. (Patient & Relationship is assumed to be Self unless otherwise indicated.)** I have not/will not seek reimbursement of this expense from any other plan or party because I: 1) am required to pay for the premiums through withholding, 2) have paid for the premiums, or 3) have already received these products and services.

If I am covered under more than one health care account, reimbursement will be made according to the payment order determined by those plans and as stated on the WageWorks Web site. Use of this service indicates my acceptance of the WageWorks User Agreement at www.wageworks.com (available upon registration; enter user name and password or click on First Time User).

CLAIMS FOR OUT-OF-POCKET EXPENSES

1. Social Security Administration (SSA) Deducted Premiums

(Medicare Part B, Medicare Part C – Medicare Advantage, Medicare Part D – Prescriptions)

Relationship to Account Holder
⬭ Self
⬭ Spouse ⬭ Dependent

Service Start Date (MM/DD/YY)

Service End Date (MM/DD/YY)

$ Annual Out-of-Pocket Cost

Patient's Name _____

2. Health Plan Premiums Not Deducted from Your Social Security Check

Relationship to Account Holder
⬭ Self
⬭ Spouse ⬭ Dependent

Service Start Date (MM/DD/YY)

Service End Date (MM/DD/YY)

$ Out-of-Pocket Cost

Patient's Name _____

3. Other Expenses ⬭ Medical ⬭ Dental ⬭ Vision ⬭ Prescriptions ⬭ Over-the-counter

Relationship to Account Holder
⬭ Self
⬭ Spouse ⬭ Dependent

Service Date (MM/DD/YY)

$ Total Out-of-Pocket Cost

Patient's Name _____

* The last 4 digits of the Social Security Number (SSN) is needed to assist us in identifying your account and to process your claim.

YOU MUST ATTACH A COPY OF APPROPRIATE PROOF OF SERVICE AND PAYMENT FOR EACH AMOUNT ABOVE.

$ **TOTAL THIS FORM**

WageWorks®
www.wageworks.com

Health Reimbursement Account (HRA)
Pay Me Back Claim Form

INSTRUCTIONS
(DO NOT FAX these instructions with your Claim)

PLEASE READ THIS BEFORE SUBMITTING YOUR CLAIM FORM

Your claim is important. To ensure we are able to process your claim, please complete the WageWorks Health Reimbursement Account Pay Me Back Claim Form. Submit your claim along with your complete documentation for the expense. Please review the guidelines below to ensure all necessary information is included when filing your claim.

Tips to Complete the HRA Pay Me Back Claim Form

- Read every box and provide all requested information.
- Type or write legibly.
- The Account Holder Name section should be completed with the Participant's First and Last Name UNLESS you are a surviving spouse of a Participant. In that case, the surviving spouse should indicate his or her name in the name field.
- Make sure to sign the form. The account holder's signature is required for processing. If a person holding a Power of Attorney for the participant is signing, please make sure he or she signs the form in the following format "*John Smith, Attorney in Fact for Jane Smith.*" Make sure the Power of Attorney is either on file with WageWorks or submitted with the first claim.
- Complete a separate form for your Dependent or Spouse.

Things to Remember When Submitting Receipts

- The itemized receipt or documentation must contain:
  - **Provider Name-** Facility name or person who provided the service or, if a purchase, where item was purchased (i.e. hospital, doctor, pharmacy, insurance company).
  - **Date of Service-** Date service occurred, date item was purchased, or coverage period if claim is for a insurance premiums.
  - **Service Description-** Detailed description of the service provided, item purchased or type of insurance.
  - **Amount-** The amount charged for the services or product or the portion not reimbursed through your insurance carrier. For insurance premiums, this is the premium amount.
  - **Patient Name-** Person who received the service or item purchased or the recipient of the insurance coverage.
- Include an itemized and legible receipt for every expense.
- Please do not include carbon copies of receipts.
- Handwritten receipts must have stamped provider information.
- Cancelled checks are only acceptable as proof of payment if accompanied by an insurance carrier statement for insurance premiums.
- If you attach multiple receipt pages, circle or check the dollar amount that is being claimed for each receipt.
- Do not use a highlighter to highlight the dollar amount or any other information on the receipt.

Instructions to Complete Sections 1-3 on the Pay Me Back Claim Form

Section 1 – Social Security Administration (SSA) Deduct Premiums (Medicare Part B, Medicare Part C – Medicare Advantage, Medicare Part D – Prescriptions)

- Complete this section if you are requesting reimbursement for a premium that is deducted from your Social Security Check.
- In the "Service Start Date" boxes, enter the first of the month in which you are eligible for Medicare Part B, C or D for the year you are claiming. In the "Service End Date" boxes, enter the last day of coverage for the year.
- Enter the annual amount of your Medicare Part B, C or D expense (the monthly amount multiplied by the number of months of coverage).
- Include a copy of your Social Security "Cost of Living Statement" as proof of your expense (typically mailed starting in November the year before it becomes effective), or any other Medicare statement that clearly indicates your Medicare B, C or D premiums.
- You will be reimbursed on a pro-rated monthly basis based on your annual premiums. The amount of the reimbursement will not exceed the monthly amount or the available funds in the account.
- If the cost is not deducted from your Social Security Check, please fill out Section 2 "Health Care Premiums Not Deducted from Your Social Security Check" on the claim form in order to be reimbursed.

Section 2 – Health Care Premiums Not Deducted from Your Social Security Check

- Complete this section if you are requesting a reimbursement for Health Care premiums that:
  - Were not deducted from your Social Security Check, *and*
  - You have paid to your health plan on an after-tax basis.
- Make sure to provide documentation from your insurer and premium showing:
  - Coverage period, such as a statement or invoice from your insurance carrier or the City of Minneapolis **AND**
  - Appropriate proof of payment such as a copy of the front and back of a cleared check, a receipt from the City of Minneapolis, or bank statement that shows automatic withdrawals.

  Both proof of coverage and proof of payment MUST be submitted for approval.
- The service start date and end date should represent the period of coverage you have paid or will pay for and are seeking reimbursement. For example, if you have paid for your plan premium for March 2013 and are seeking recurring reimbursements through the end of the calendar year, the service start date should read 03/01/2013 and the service end date should read 12/31/2013.
- If the insurance premiums are deducted from a payroll check, there must be clear indication that the deductions are taken on a post tax basis (after taxes).

  Note: Pre-tax deductions for premiums from payroll checks are not eligible for reimbursement.

Section 3 – Other Expenses

- Complete this section if you are requesting reimbursement for other out-of-pocket expenses such as co-pays, dental services, eligible items or expenses.
- You may add up more than one receipt or expenses incurred for several small eligible expenses and enter that amount on the claim form.
- When submitting several receipts or pieces of documentation please circle the expense amounts, date of service and description of service on each receipt or supporting documentation.
- Indicate the earliest service start date on the claim form if requesting reimbursement for several expenses.
- Indicate on the claim form who incurred the expense.
- Explanations of Benefits (EOBs) are recommended if your insurance covered any portion of the expense.

Tips to Submit the HRA Pay Me Back Claim Form

- Do not use a cover page when faxing.
- You can verify the claim status online at www.wageworks.com after processing. Please wait 2 business days from receipt of your claim for processing.
- You will be notified via email of the status of your claim if have a valid email address on file. To add or change the default email address, log on to www.wageworks.com and select Edit My Profile from the welcome screen.
- Make a copy of the form and all attachments; send only copies, keep the originals for your records if submitting via postal mail.

FAX: (855) 291-0625, or Mail to: Claims Administrator, FBWW, PO Box 14326, Lexington, KY 40512